Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ACTIONCARE PAIN MANAGEMENT
10450 BRIAN MOONEY
EL PASO TX 79935

Respondent Name

HARTFORD INS CO OF THE MIDWEST

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-3256-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "'Primary diagnosis invalid for this carrier.' The diagnoses we used were provided by her treating doctor. According to her treating doctor's office the diagnosis were based on MRI of the lumbar spine results." "…[Claimant] was authorized 20 sessions of a chronic pain management program."

Amount in Dispute: $20,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No further treatment per peer review."

Response Submitted by: Specialty Risk Services, 1851 East 1st Street #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 23, 2010 August 24, 2010 August 25, 2010 August 26, 2010 August 27, 2010 August 30, 2010 August 31, 2010 September 2, 2010 September 3, 2010 September 7, 2010 September 9, 2010 September 10, 2010 September 13 2010 September 14, 2010 September 15, 2010 September 17, 2010 September 27, 2010	Chronic Pain Management – CPT Code 97799-CP (8 hours X 20 dates = 160 hours)	$20,000.00	$0.00

September 28, 2010 September 29, 2010 September 30, 2010			

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 21, 2011
   - 214-Workers compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Services denied. Please contact SRS Claim Examiner regarding these charges.

Issues

1. Does a compensability issue exist?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the chronic pain management program based upon reason code "214-Workers compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Services denied. Please contact SRS Claim Examiner regarding these charges."

   The July 11, 2008 Contested Case Hearing decision found that "The Claimant's injury sustained on January 7, 2008 does extend to and include a disc bulge at L4-5 and L5-S1 and an annular tear at L4-5. The Claimant does have disability from February 4, 2008 through May 15, 2008 as a result of an injury sustained on January 7, 2008. The subsequent medical condition of the Claimant sustained on February 4, 2008 is not the sole cause of the Claimant's disability beginning on February 4, 2008 through the present."

   Review of the submitted medical bills finds that the disputed chronic pain management was treatment for the following diagnosis codes: 847.2-Lumbar sprains and strains of other and unspecified parts of back; 724.2-Lumbago; and 724.3-Sciatica. Therefore, the Division finds that the requestor has supported that the disputed treatment was for the compensable injury.
2. Review of the submitted documentation finds that the requestor billed for eight hours of chronic pain management per disputed date. In the position summary the requestor indicated that "…[Claimant] was authorized 20 sessions of a chronic pain management program." In support of this position, the requestor submitted a report from SRS dated July 26, 2010 that authorized "Chronic Pain Mgmt Program 5x2". Therefore, the requestor has supported that 10 sessions of chronic pain management were preauthorized.

   The Requestor submitted four (4) Chronic Pain Management Program Treatment Reports, Chronic Pain Management Program Plan of Care report, Chronic Pain Management Program Week 2 and 3 reports, and Chronic Pain Management Program Discharge Team Conference Report to support the billed services. These reports do not support the eight hours per disputed date of service billed; therefore, reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		5/22/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.